MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

[redacted] STATE FILE NUMBER 63-032124

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4528

FILED SEP 11 1963

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
1			
2	3b38		2
3			
4	1		
5	0		
6			
7	0		
8	2		
9	334X		
10			
11			
12	86-0		
13			

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
   a. COUNTY: Jackson
   b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
   Length of stay in 1b: 58 years
   c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Swope Ridge Nursing Home
   Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Missouri COUNTY: Jackson
   c. CITY OR TOWN: Kansas City
   Inside Limits: Yes ☒ No ☐
   d. STREET ADDRESS (If outside, give location): 1528 Brush Creek Blvd
   Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First BESSIE Middle Last ALLCORN

4. DATE OF DEATH: Month August Day 12 Year 1963

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 1-31-88

9. AGE (last birthday): 75
   IF UNDER 1 YEAR: Months ___ Days ___
   IF UNDER 24 HR: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Office Manager

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Missouri City, Mo.

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13a. FATHER'S NAME: Andred W. Allcorn

13b. MOTHER'S MAIDEN NAME: Frances E. Mitchell

14. NAME OF HUSBAND OR WIFE: -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi: No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Marie Allcorn, 1528 Brush Creek

18. CAUSE OF DEATH (Enter only one cause per line)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Chronic Brain Syndrome
   Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
   DUE TO (b): Cerebral Arteriosclerosis - advanced
   DUE TO (c): Generalized Arteriosclerosis - Advanced
   INTERVAL BETWEEN ONSET AND DEATH:
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).
   PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

MEDICAL CERTIFICATION

21. I attended the deceased from 10-30-61, to 8-2-63 and last saw her/him alive on 8-2-63
   Death occurred at 4:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John H. Wheeler M.D.

22b. ADDRESS: 4320 Wornall Road, K. C. Mo.

22c. DATE SIGNED: 8-13-63

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Aug. 14, 1963

23c. NAME OF CEMETERY OR CREMATORY: Missouri City Cemetery

23d. LOCATION (City, town, or county) (State): Missouri City Missouri

24. FUNERAL DIRECTOR ADDRESS: D.W.Newcomer's Sons, 1331 Brush Creek Blvd. Kansas City, Mo.

25. DATE RECD. BY LOCAL REG.: 8-14-63

26. REGISTRAR'S SIGNATURE: Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

Dr. John Wheeler
4320 Wornall Rd.
After 12:30 PM

fe 1-2338

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Tom Fowler

Licensed Embalmer No. 4915

P. O. Address KC Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.